



# Estimation of Out-of-Pocket Expenses Form

## PROFESSIONAL SERVICES | (WI ACT 146)

Please work with your health care provider to complete the required fields listed below. By providing the required information, a more complete “best estimate” of the customer/patient’s out-of-pocket expenses can be given.

If Arise is not your primary insurer, please provide the Estimation of Out-of-Pocket Expenses from your primary carrier.

MEMBER INFORMATION		PROVIDER INFORMATION	
Member Name:		Clinic Name:	
Member Number:		Clinic Tax ID:	
Member Group Number:		Clinic Billing Address:	
Patient Name:		Clinic Servicing Address:	
Patient Date of Birth:		Servicing Provider Name:	
		Referring Provider Name:	

### SERVICE INFORMATION

Procedure Codes	Modifiers	Date of Service	Units	Place of Service	Diagnosis Code	Charges
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

**Total:**  
\_\_\_\_\_

**Please mail this completed form to:**  
 Arise Health Plan  
 P.O. Box 11625  
 Green Bay, WI 54307-1625

Disclaimer: A decision on payment can only be made when all necessary claim information is received and reviewed in accordance with all the provisions and limitations of the health policy/plan including, but not limited to: requirements for medical necessity, prior authorizations, pre-certifications, exclusions for work-related injuries, provider network affiliations, and pricing adjustments due to negotiated transplant coverage. © 2016 WPS Health Plan, Inc. All rights reserved. 28930-085-1604